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Abstract	We describe a case of shibari, a double hanging sexual asphyxia practice, which ended fatally for one of the two women involved. We present the autopsy findings and a psychiatric and psychometric evaluation of the surviving participant. The survivor had a borderline personality disorder, had suffered sexual abuse as a child, and had a history of illicit substance consumption, self-harm behavior, and sexual dysregulation. This case study raises doubts regarding the safety measures adopted by participants in masochistic practices and the engagement of people with psychiatric disorders in these extremely dangerous games. Further case studies of living participants in such games are likely to shed light on this practice and facilitate treatment.

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Shibari: Double Hanging During Consensual Sexual Asphyxia

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Abstract We describe a case of shibari, a double hanging sexual asphyxia practice, which ended fatally for one of the two women involved. We present the autopsy findings and a psychiatric and psychometric evaluation of the surviving participant. The survivor had a borderline personality disorder, had suffered sexual abuse as a child, and had a history of illicit substance consumption, self-harm behavior, and sexual dysregulation. This case study raises doubts regarding the safety measures adopted by participants in masochistic practices and the engagement of people with psychiatric disorders in these extremely dangerous games. Further case studies of living participants in such games are likely to shed light on this practice and facilitate treatment.

Keywords Sadomasochism · Autoerotic asphyxia · Forensic psychology · Paraphilias · Shibari

Introduction

Voluntary sexual asphyxia is a type of asphyxiation that is induced to increase sexual gratification. This paraphilia is not sufficiently common to be included as a specific disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) (American Psychiatric Association, 2000) and *International Classification of Diseases* (ICD-10) (World Health Organization, 1992). It is a dangerous form of sexual masochism involving sexual arousal by oxygen deprivation (hypoxyphilia) achieved by ligature, plastic bags or chest compression. In most cases, hypoxyphilia represents a form of paraphilia called BDSM. This compound acronym is derived from the terms bondage and discipline (B & D), dominance and submission (D & S), and sadism and masochism (S & M). BDSM encompasses a wide spectrum of activities that include being physically restrained through the use of handcuffs, cages, chains, and ropes; receiving punishment or pain by means of paddling, spanking, whipping, burning, beating, electrical shocks, cutting, rape, and mutilation; psychological humiliation and degradation may also be involved. Shibari is a form of BDSM. The term is a Japanese word that means to tie or to bind. It is used in Japan to describe the artful use of twine to tie objects or packages. It involves the use of thin pieces of rope to bind the submissive partner in ways that are meant not only to be artistically beautiful, but also to heighten the sensation of orgasm. In a recent Australian study (Richters, De Visser, Rissel, Grulich, & Smith, 2008), out of a representative sample of 19,307 respondents aged 16-59 years interviewed by telephone, 1.8 % of the sexually active people (2.2 % of the men, 1.3 % of the women) said they had been involved in BDSM in the previous year.

Paraphilias are often found in borderline personality disorder (BPD). BPD is a serious mental health problem characterized by unusual levels of instability in mood, idealization and devaluation episodes, a disturbance in the individual's sense of self, and unstable interpersonal relationships, self-image, identity, and behavior. BPD patients are difficult to treat, have an increased death rate, often present self-harm behaviors, and are subject to intense emotional dysregulation. In their study on sexual practices in BPD patients, Zubenko, George, Soloff, and Schulz (1987) found that 11 % of the patients also had a diagnosis of paraphilia.

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Women with BPD frequently adopt complicated sexual behaviors (Neeleman, 2007) and exhibit marked impulsivity and a temperamental disposition toward sensation-seeking (Cloninger & Svrakic, 2000), which exposes them to high-risk sexual practices. Most women with BPD have an insecure attachment style (Levy, Meehan, Weber, Reynoso, & Clarkin, 2005) and consequently tend to have sex to reassure themselves that their partner cares about them and to captivate their partner's attention.

Many studies have been conducted to identify specific variables that correlate with the development of BPD. Two studies have suggested that 60–90 % of women with BPD have experienced childhood sexual abuse (CSA) (Yen et al., 2002; Zanarini, Frankenburg, Reich, Hennen, & Silk, 2005). Indeed, numerous studies on the relationship between BPD and CSA have reported that the two phenomena are closely associated (Katerndahl, Burge, & Kellogg, 2005; McLean & Gallop, 2003; Ogata et al., 1990; Soloff, Lynch, & Kelly, 2002; Trull, 2001; Weaver & Clum, 1993; Zanarini et al., 2002). In a meta-analysis of 37 studies involving over 25,000 subjects, Oddone Paolucci, Genuis, and Violato (2001) found that sexual abuse in childhood was associated with promiscuity in adulthood. In a review of 42 empirical studies, Beitchman, Zucker, Hood, daCosta, and Akman (1991) came to the same conclusion. Sansone, Gaither, and Songer (2002) found that childhood abuse was associated with BPD and that self-harm behaviors and multiple types of abuse were more likely to precipitate self-harm behavior. Clinically, this suggests that patients who display high degrees of self-harm behavior have probably been subjected to multiple forms of childhood abuse.

In this report, we present a fatal case of double hanging consensual sexual asphyxia, with a summary of the event, the autopsy findings, and a psychiatric evaluation of the surviving participant. Cases in the literature regarding deaths resulting from asphyxiation induced to achieve sexual arousal focus primarily on either males (Quinn & Twomey, 1998; Sauvageau & Racette, 2006) or females (Byard, Hucker, & Hazelwood, 1993; Gosink & Jumbelic, 2000) involved in autoerotic practices. Only one previous study described sexual asphyxia practices in a couple (Oklota, Niemcunowicz-Janica, Sackiewicz, Ptaszynska-Sarosiek, & Szeremeta, 2010).

Case Report

After having consumed a light dinner accompanied by a large quantity of alcohol, two young women (SU and DE) and an older Italian man went on to play an erotic game that included bondage practices in an isolated, public location at about 4 am that night. The two women, who remained dressed, without either exposing their genitals or receiving sexual stimulation, were tied to each other in a sort of pendulum so as to counterbalance each other, thereby practicing a Japanese erotic figure (Shibari). The ropes were slung over metal tubes in the basement of a local federal income tax building underground. When one woman went down, the other one went up, thus causing a feeling of suffocation that was considered sexually arousing. While this game was being played, DE fainted (and lost urine), which resulted in SU remaining suspended and in both her and SU being asphyxiated for an extended period of time. As the man involved in the game did not have a knife at hand, he was unable to cut the rope immediately. When he did manage to release the two women, DE was dead and SU was in critical condition. The man was arrested and is presently awaiting trial.

The Victim: Autopsy Findings

DE, who was 23 years old, 171 cm tall, and weighed 121 kg (BMI = 41.38), was found with 4 ropes that had been used to tie multiple knots around her joints and had been passed several times around her chest. The death can be ascribed to violent mechanical asphyxia. Indeed, the ridges found in the cervical region during the external examination and the underlying hematic infiltrations were considered to be clear signs of hanging. The external examination of the cadaver revealed signs of cervical compression, indicating that a rope had been passed around the neck at least twice. The histological examination confirmed the nature of the lesions, thus proving that they did not result from the suspension of the cadaver, but had been caused by a harmful object on a living subject. The toxicological tests disclosed the presence of a moderate quantity of alcohol and cannabinoids in the blood, though these substances were not directly involved in the young woman's death. The woman had history of psychiatric treatment.

We define this event as an incomplete hanging, in which the death may be ascribed not only to asphyxiation, but also to vascular and autonomic nervous processes. The reason to why DE died and SU did not may lie in differences in the young women's response to asphyxia as well as in the degree of compression exerted by the ropes on the chest.

The Survivor

SU, who is 24 years old, 164 cm tall, and weighs 83.60 kg (BMI = 30.85), was untied where the event had occurred and was taken to the hospital emergency ward because of acute respiratory failure that required ventilatory support. The acute respiratory failure was caused by prolonged asphyxia, caused by a rope that had been wound around the young woman's neck. Upon admission to Sant'Andrea Hospital, SU had severe acute respiratory failure and was in a coma (GCS = 3). The alcohol level in her blood was 1.08 and there

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were traces of cannabinoids in her urine. The coroner (who also examined SU) observed the presence of "red marks around the patient's neck that could be ascribed to strangulation." SU was hospitalized in intensive care, where she underwent a CT scan, a chest CT, an MRI, and an EEG. These diagnostic tests did not disclose any pathologically significant findings. Some days later, when SU had regained her alertness, orientation in time and space, and was hemodynamically stable and breathing spontaneously, she was transferred to the internal medicine ward. It was in this ward that she first came into contact with a psychiatrist, which led to a series of interviews, even following her discharge from hospital, and to the administration of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-ICV) (First, Spitzer, Gibbon, & Williams, 1997a), the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) (First, Spitzer, Gibbon, & Williams, 1997b), and a psychodiagnostic battery of tests. During the first psychiatric interview, the patient said she could not remember anything regarding the "accident," this probably being due to the strong neuronal damage caused by the prolonged hypoxia.

SU reported to have achieved all the normal development milestones and had successfully attended elementary school. SU, who is an only child, stated that from the age of 12 years her father (salesman for a construction company) had often been absent for business reasons, sometimes even for months. SU reported that he was physically violent towards her mother, even in her presence; during the disputes, the father screamed and slapped the mother but was never violent towards his daughter. Despite the many family rows, police intervention was never required nor were there any complaints or hospitalizations for beatings. Her mother (a civil servant) was described as an excessively authoritarian woman; SU reported that her mother often took decisions, not allowing her to make choices independently. Therefore, from a relational point of view, the parents appeared dysfunctional. There were no cases of mental illness in her family history. SU grew up with a lot of babysitters as her parents got home from work very late in the evening. She described the relationships with the baby-sitters as shallow and did not preserve a meaningful memory of any of them. She reported a single incident of sexual abuse at the age of 11 years by a person outside the family entourage. SU related that the abuser was about 50 years old, though she refused to say more about this episode because she found the memory too painful. According to her statement, SU immediately informed her parents of the abuse but they decided not to report it to the police so as not to have go through the time-consuming procedure. She said "This made me feel very empty." Following the abuse, SU started consuming cannabis before going on to hallucinogens, cocaine, and heroin. In order to treat this addiction, at the age of 16 years, she entered a therapeutic community for substance abusers and stayed there for 3 years. While in this community, she gradually reduced her substance abuse, although she admitted to still being a regular cannabis consumer. She said "I get anxious and confused, but after I consume cannabis my thoughts become clearer."

As an adolescent, the patient also had a history of non-suicidal self-harm behavior. From the age of 12 years, she had often cut herself with razor blades or intentionally burned herself. She said "At first they were cleansing acts; I always feel dirty; I started because I can always smell the man who abused me. The pain helps me to feel myself." In particular, SU described this smell as a pseudohallucination. The patient's clinical history did not include psychotic symptoms.

SU started menstruating at the age of 10 years. Her period was not regular until she started taking the birth-control pill at the age of 18 years. Before adopting this contraceptive method, she had used condoms and had never become pregnant. She did not suffer from premenstrual syndrome. From the age of 12 years, SU used her sexuality as a bargaining chip to obtain drugs or other material goods. She did not report having had any homosexual relations. She said that her main source of sexual satisfaction was masturbation, though she did not report any peculiar sexual fantasies in this regard. Throughout her life, SU's personal relationships have been marked by emotional instability. She never had any close friends and none of her relationships lasted more than a few months. All her personal relationships were characterized by alternating love and hate, idealization and devaluation, with a stable sense of the other person never being achieved. She reported having difficulty in controlling her anger in all her relationships. The only important love affair she had had was with a drug abuser who was much older than she was, though the relationship was not sexually satisfying because the man suffered from impotence.

SU succeeded in obtaining a school-leaving certificate and in getting a job. She related that she had become interested in sexual masochism only 9 months before the accident and she had performed BDSM several times with different partners. She said "I was sad and bored and I tried BDSM simply out of curiosity. I wanted some excitement. After someone had spoken to me about this practice, I made a search on internet and found films that aroused my curiosity." SU came into contact with a community of sadomasochists online, with whom she attended some meetings and met partners. The patient also experienced other dangerous erotic games, such as the use of whips or fire to achieve sexual pleasure. She said "The initial pain turned into pleasure, I got pleasure from playing these games." SU denied the danger of these sexual practices, being only superficially aware of the threat they may pose to life, explaining that these erotic games have an escape or a fail-safe mechanism. When told that her partner had died, she cried for a couple of minutes, making a superficial facial expression and few physical movements. In the following 10 min, as well as during the other psychiatric sessions, she smiled spontaneously during the conversation.

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In the days following her partner's death, she appeared to be superficially upset and reported the desire to be "asexual." According to her medical history, the patient had not previously undergone any psychiatric pharmacological therapy, but only psychotherapy performed on and off for 3 years, though with limited improvements. She said that she had undergone psychotherapy to treat depression, revealing only a small part of her sexual practices to the therapist, who according to SU did not display much interest or ask any specific questions in this regard. While undergoing psychotherapy, SU had continued taking illicit substances but had ended cutting. The psychotherapy was ongoing at the time of the fatal incident.

SU said that her family not only felt that the publicity her sexual practices had aroused had violated their privacy but that the investigation and interviews had had an upsetting effect on her parents and friends. Her closest relatives were not aware of the victim's autoerotic activities and her mother had addressed the issue of SU's and the victim's privacy by saying that the news in the media had caused great embarrassment.

She completed the Wechsler Adult Intelligence Scale-Revised (WAIS-R) (Wechsler, 1981), the Millon Clinical Multiaxial Inventory (MCMI-III) (Millon, 1994), the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), and Raven's Progressive Matrices (PM-38) (Raven, 1938). Her Full-Scale IQ on the WAIS-R was 96, with no significant differences between Verbal (IQ = 94) and Performance (IQ = 99) or between subtests. On the PM-38, she fell within the 50th percentile, which indicates a medium abstraction ability. On the MCMI-III (Personality Code: 6A3**2A2B* 6B458A1+8B″7//C*SP+; Syndrome Code: T**A*//CC**SS*), she scored over 85 points in scale C (Borderline), a serious personality scale, and in the 6A (Antisocial) and 3 (Dependent) personality scales, indicating the possible presence of those personality disorders, while her scores on scales 2A (Avoidant) and 2B (Depression) were between 75 and 84 points. On Axis I, scale T (Drug Addiction) was over 85 points. SU's overall constellation, which was seriously disturbed, corresponded to a personality with disorganized behavior, inadequate affectivity associated with fear and mistrust of others, though with a combative temperament. SU's marked depression also emerged, as did a history of substance abuse and difficulty in controlling impulses. On the MMPI-2 (Welsh Code: 49′708615-23/F-L:K#TRIN: VRIN:Fb′), she scored high on two clinical scales (Hypomania and Psychopathic deviance) and on three Content and Supplementary Scales (OBS, ASP, MAC-R). The profile that emerged pointed to alienation from society, impulsivity, low tolerance of frustration, and alcohol consumption.

According to the DSM-IV-TR, the patient's clinical phenomenology was congruent with a diagnosis of Past Multiple Substance Dependence (F19.20), Sexual Masochism (F65.5), and Borderline Personality Disorder (F60.31). There were also some elements of Bipolar Disorder NOS.

Discussion

This report differs from most previous reports of asphyxia fatalities insofar as the latter were mainly of solitary men and women. In this report, we analyzed a case of a masochistic game called shibari, played by two young women that ended in death for one of them. This case is relevant to therapeutic and social issues because it sheds light on a little-known practice.

The three protagonists involved in the event met on-line. While playing shibari, the victim, who was severely obese and had a history of psychiatric treatment, died as a result of violent mechanical asphyxia; the survivor suffered severe respiratory failure and was comatose. One noteworthy issue that emerged from the reconstruction of this event was the lack of safety during consensual erotic games. Death as a result of asphyxia games is unlikely to occur when another participant and a supervisor/instructor are involved. In this case, the master was unable, as he did not have a knife at hand, to interrupt the state of equilibrium between the two young women, who were bound to each other with ropes, one of which passed around their necks. Part of the excitement induced by BDSM is attributed to the complete trust required between the dominant and submissive partners, the emotional ties during play often being very powerful. The two women clearly overestimated the instructor's technical skills and underestimated the possible consequences of his impaired lucidity due to the consumption of alcohol and cannabinoids. When engaging in consensual masochistic games, it is mandatory that basic safety procedures and tools should not be forgotten; indeed, participants should be aware that fatalities in asphyxia games occur when the escape mechanism fails or the participants become unconscious through hypoxia. Although numerous fatalities have been reported, few studies have focused on the treatment or prevention of asphyxia in such circumstances (Behrendt, Buhl, & Seidl, 2002).

The survivor presented unequivocal signs of inadequately treated BDP and its consequences. After a childhood of loneliness with no reference figures of any importance, she suffered sexual abuse, which was downplayed by the parents who decided not to report the crime. The patient's BPD traits appear to have started at that time, even if it is clearly the outcome of an affection-deprived childhood and adolescence. The traits that emerged from the survivor's clinical picture were drug consumption and addiction, non-suicidal self-harm behavior, distorted sexual behavior, and emotional instability in relationships. Lastly, her masochistic sexual behavior was triggered by a general sense of sadness and a desire for excitement. The young woman's clinical history

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reflected unsuccessful psychotherapeutic treatment, which highlights the possible need for psychotherapists to focus on the prevention of dangerous behaviors in BDP patients and on the involvement of people with psychiatric disorders in these extremely dangerous games. If the psychotherapist had investigated SU's new sexual interest in more detail, the tragic outcome might have been prevented in this case. It should, however, be borne in mind that, owing to the lack of information available on sexual masochistic rituals in our culture, it may have been impossible to offer a rational treatment package.

The fact the victim also presented a psychiatric disorder, and that both women had attended courses in sadomasochistic practices, raises questions regarding the involvement of people with psychiatric disorders in these extremely dangerous games. Moreover, neither of the young women had checked whether the instructor had the equipment required to perform the game safely, which may also be related to their personality, and all the participants had been drinking alcohol.

The case presented here also highlights some ethical issues, including upsetting a family and local community during an investigation as well as the effects of news released by the media on the memory of the victim among relatives and friends. Strict privacy procedures need to be designed and implemented in order to avoid any negative social impact, even though information is an important means of raising awareness among the public about the dangers of various forms of erotic asphyxia.

Lastly, this case also raises issues regarding the increasingly widespread availability of paraphilia and pornography in our society, which warrants further research as well as effective preventive measures. In Italy, there is a general social intolerance to sexual paraphilias, which are greatly stigmatized within an enduring patriarchal social system. However, owing to the ease with which access can be gained to paraphilias (knowledge and images through internet), paraphernalia and pornography by both individuals and organized groups, the number of cases of lethal paraphilic syndromes have increased recently and may rise even further in the future unless a widespread sexual education campaign, including such syndromes, is conducted. Moreover, psychiatric disorder, such as BPD, probably accounts for the increased mortality rate because it is characterized by impulsivity and low self-protection. Given the number of fatalities that result, or may result from this practice, this topic warrants further research and that more case studies of living participants should be collected.

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